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F 000	INITIAL COMMENTS Surveyor: 32767 This was a recertification survey conducted at Wisconsin Veterans Home Stordock from 1/21/15 to 1/27/15. # of federal citations issued: 4 The most serious citation is F441 cited at a scope/severity level of E (pattern/potential for harm). Census: 197 Sample size: 30 Supplemental sample size: 3 Survey coordinator: #32767	F 000		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Surveyor: 21654 Based on observations, record review, staff and member interviews, the facility did not ensure that a member at risk for pressure ulcers received	F 314		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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necessary services to prevent new ulcers from developing in 1 (member #5) of 10 sampled members reviewed for pressure ulcer risk.

The facility had assessed member #5 to be at high risk for the development of pressure related ulcers. The member spent most afternoons lying in bed on back. The member's plan of care indicated use of pressure reducing heel boots at night when in bed. The member's care plan did not include interventions to free float heels while in bed during the day, per the facility's standard of practice.

Findings include:

The facility's Wound Prevention and Treatment Program standard of practice dated June 2014 indicated skin care interventions for members assessed to be at high risk for the development of pressure ulcers to include implementation of low and moderate risk interventions (which includes to float heels).

The Quick Reference Guideline entitled "Prevention and Treatment of Pressure Ulcers", published by the National Pressure Ulcer Advisory Panel in 2014 indicated," Repositioning for preventing heel pressure ulcers. Ensure that the heels are free of the surface of the bed. Use heel suspension devices that elevate and offload the heels completely. Ideally, heels should be free of all pressure. A state sometimes called "floating heels."

Member #5's admission face sheet dated 4/16/08, indicated the member had diagnoses to include congestive heart failure, renal failure, diabetes with peripheral neuropathy, anemia,

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obesity, degenerative joint disease of the knees and cerebral vascular accident.

Member #5's most current MDS (minimum data set) assessment dated 10/27/14, documented the member to be cognitively intact (scoring a 12 of 15 on the cognition screen. The higher the score, the more cognizant). Additionally, the MDS documented the member required extensive assistance from staff to perform bed mobility and transfers, was non ambulatory, had range of motion deficits of one lower extremity, had constant pain, and was at risk for pressure ulcers.

A nursing entry located in the member's medical record dated 4/4/14, documented "Bilateral buttocks observed 3 small superficial open areas on right buttocks, several small intact dark red/purplish areas on left buttocks, also non blanchable. Has partial thickness loss of skin layers that presents as an abrasion or blister (Pressure stage II)."

The member's most recent pressure ulcer CAA (care area assessment) dated 5/7/14, documented "Member remained at high risk for pressure related skin breakdown. Member receives twice weekly skin checks, has heels elevated off air mattress, ROHO cushion for chair, is repositioned every 2 hours. Care plan was updated and approaches related to new incontinence were added. Also added approach re: floating heels as it is done whenever member is in bed. Member has had a history of a pressure ulcer but this was healed last month."

The member's most recent Braden score for prediction of pressure ulcer risk dated 1/17/15, documented member #5 was at high risk for the

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development of pressure ulcers.

The member's most current impaired skin integrity plan of care dated 1/15/15, included an intervention dated 8/29/14, "Member has heel lift boots."

The member's most recent PMC (personalized member care) sheet, utilized by direct care staff dated 1/22/15, included "Heel Medix Boot both feet to avoid pressure on HS (evening) off AM."

On 1/21/15 from 1:15 p.m. until 3:15 p.m., surveyor #21654 made periodic observations of member #5 lying in bed on back with both socked heels in full contact with the mattress.

On 1/22/15 at 8:45 a.m., surveyor #21654 observed member #5 lying in bed on his back with both socked heels in full contact with the mattress. The member was observed in this same position without heels free of pressure until 9:10 a.m.

On 1/22/15 at 8:50 a.m., surveyor #21654 interviewed member #5. Member #5 stated "I am up for breakfast then go back to bed. I get up for therapy at around 9:30 a.m., then am up until just after lunch. The rest of the afternoon I spend in bed. It's more comfortable for me and I always lay on my back. Staff only put the heels boots on at night. Pillows under my calves are never used during the day. I can't feel anything from my ankles down. I have difficulty lifting my heels off the bed due to the four knee surgeries I've had."

On 1/22/15 at 9:00 a.m., surveyor #21654 interviewed member #7. Member #7 is member #5's spouse and also occupies member #5's

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F 314	Continued From page 4 room. Member #7 verified to the surveyor that member #5 is in bed "a lot" during the day, does not wear heels boots, and there is no pillow used under the member's calves. On 1/22/15 at 9:05 a.m., surveyor #21654 interviewed CNA (Certified Nursing Assistant)-C regarding member #5. CNA-C stated, "(Member #5) wears heels boots at night, not during the day. (Member #5) is in bed from 1:00 p.m. until around 4:00 p.m. every day per his spouse. (Member) used to wear the boots all the time but is up and down a lot during the day." On 1/22/15 at 9:12 a.m., surveyor #21654 and RN (Registered Nurse)-F observed member #5's heels. Both of the member's feet were observed to be edematous and pale in color. RN-F verified that neither of the member's heels were red and the skin at the heels was intact. RN-F stated, "(Member)has an Isoflex mattress. When is in bed, shoes are always off." RN-F verified the member's current care plan included an intervention to prevent pressure to the heels was only applicable during the night and stated, "It makes sense that if (member #5) is in bed for extended periods of time during the day, and has diabetes and edema, heels are free of pressure. I will change (member's) plan of care right now." Review of the member's updated PMC dated 1/26/15, included the intervention "Heel Medix boot both feet to avoid pressure when in bed."	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a	F 315		

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resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

This REQUIREMENT is not met as evidenced by:
Surveyor: 21654

Based on observations, record review and staff and member interviews, the facility did not ensure that 1 (member #7) of 10 members utilizing indwelling catheters received appropriate services to prevent UTI's (urinary tract infections).

Member #7 utilized an chronically indwelling Foley catheter due to urinary retention and hydronephrosis with stints placed. The member had a recent history of two UTI's in the past month and had a history of MRSA (Methicillin Resistant Staph Aureus) in the urine and nares. The member also had recent open abdominal surgery due to bowel obstruction (12/2/14). Since the surgery, the member spent more time in bed resting. The facility did not develop a care plan intervention to ensure when the member was in bed during the day, that the urine collection leg bag remained below the level of the bladder.

Findings include:

The facility utilizes the standard of practice entitled, "Assisting in Long Term Care" sixth edition published by Gerlach and Hegner

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regarding catheter care. The standard indicated, "Points to keep in mind when residents use a leg bag include the bag must be placed so there is a straight drop down from the catheter."

The facility's policy regarding Foley catheter care dated March 2012 indicated catheter and drainage tubing shall be positioned to promote drainage and prevent back flow of urine into the bladder.

The facility's policy regarding use of urinary drainage leg bag dated April 2012 indicated the drainage bag shall remain below of the member's bladder at all times.

Member #7's admission face sheet dated 4/16/08, indicated the member had diagnoses to include venous insufficiency edema, history of chronic UTI (urinary tract infection), urinary retention due to Parkinson's disease requiring use of a chronically indwelling Foley catheter, history of MRSA in urine and nares, and recent open abdominal surgery (12/2/14) related to small bowel obstruction.

The member's most recent MDS (minimum data set) assessment dated 12/23/14, indicated the member to be cognitively intact, scoring a 15 of 15 on the cognition screen. The higher the score, the more cognizant. The member was their own decision maker.

Review of the member's medical record indicated that the member had been treated with antibiotics for diagnosis of UTI's on 12/22/14 and again on 1/5/15.

A physician's note located in the member's

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medical record dated 1/7/15, documented "MRSA in urine. Allergic to Sulfa. Should avoid antibiotics whenever possible because has multiple resistance already."

The member's urinary elimination/Foley catheter plan of care dated 3/28/14, did not include interventions relating to keeping the leg bag below the level of the bladder while in use during the day, when in bed.

The member's most recent PMR (personalized member care) sheet dated 1/22/15, and utilized by direct care staff indicated an intervention to include, "Indwelling catheter. Leg bag in a.m., bed bag at night."

On 1/21/15 at 1:30 p.m., surveyor #21654 observed CNA (Certified Nursing Assistant)-C assist member #7 into bed by removing shoes and elevating lower extremities. The head of the member's bed was already elevated at approximately 15 degrees. The CNA offered to elevate the foot of the member's bed, but the member preferred use of a rolled up blanket under the knees and the CNA placed a pillow under the members's calves to elevate the lower extremities. It was noted by the surveyor that the member was utilizing a leg bag which was secured to the left lower extremity just below the knee and was not below the level of the bladder while the member was positioned in bed. During periodic observations of the member from 1:30 p.m. until 2:35 p.m., the surveyor noted that the member continued to lay in bed with the urinary collection leg bag not below the level of the bladder.

On 1/21/15 at 1:35 p.m., surveyor #21654

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interviewed member #7. Member #7 indicated to the surveyor that since the open abdominal surgery had been performed in December of 2014, the member spent more time in bed during the day, due to pain, anxiety and fatigue. The member stated, "I've had many UTI's. I always keep my leg bag on when I lay down during the day. Staff haven't talked to me about the leg bag placement while in bed or elevating the head of my bed when I lay down during the day. I switch the leg bag from one leg to the other leg every day. I have to elevate my legs because I have such a problem with swelling in my ankles and feet."

On 1/21/15 at 2:15 p.m., surveyor #21654 interviewed RN (Registered Nurse)-G regarding member #7. RN-G stated "If members are in bed, they shouldn't have a leg bag on to prevent back flow of urine into the bladder."

On 1/21/15 at 2:35 p.m., surveyor #21654 interviewed CNA-D regarding member #7. CNA-D stated "If member's lay down during the day, we keep their leg bags on. We only use the bed bag on at night to ease the pressure of the bands off the legs." CNA-D verified to the surveyor that she was unaware of the need for interventions to include elevating the head of the bed or other interventions to ensure no back flow of urine from the urinary collection leg bag into the bladder when member's were in bed during the day and were utilizing leg bags.

On 1/21/15 at 2:50 p.m., RN-G approached surveyor #21654 and stated, "I looked at the member (#7) and isn't in the best position in bed for drainage (of urine). Did the CNA offer to elevate the head of the bed? There is no directive

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F 315	Continued From page 9 on the PMC to keep the leg bag below the level of the bladder. It just states leg bag during the day and bed bag at night". On 1/22/15 at 8:40 a.m., surveyor #21654 interviewed CNA-C regarding member #7. CNA-C stated, "(Member #7) leaves the leg bag on all day. Since surgery, (member) lays down in the afternoons. Before that, was not laying down and was much more active. Staff sometimes assist taking off (member's) shoes to get into bed during the day, it just depends on request and energy level that day. There is no direction when (member) lays down regarding the catheter leg beg in relation to the bladder." On 1/22/14 at 9:00 a.m., surveyor #21654 observed member #7 get into bed. The head of the bed was elevated to approximately 15 degrees. The member stated, "I usually have the head down flatter. I need to get my left leg up because it is starting to swell and I need to get my right leg up because that is swollen too." It was noted that the urinary collection leg bag was secured to the member's right ankle and when positioned in bed, the leg bag was not below the level of the member's bladder. Review of member #7's PMC dated 1/26/15, indicated no revision to the plan of care regarding positioning of the member while in bed utilizing a urinary collection leg bag to ensure the leg bag was below the level of the bladder during the day.	F 315		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any	F 329		

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F 329	Continued From page 10 drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Surveyor: 21654 Based on record review and staff interviews, 2 (member #31 and #15) of 31 sampled and supplemental members drug regimen had not been free from unnecessary drugs. Members #31 and #15 had been placed on antibiotics without meeting clinical or laboratory criteria for definition of a UTI (urinary tract infection). Findings include:	F 329		

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F 329	Continued From page 11 The facility utilized the Loeb criteria for standard of practice for clinical definitions of infections. The Loeb criteria indicated the purpose of the criteria was to define the criteria used to determine treatment with antibiotics and to define the criteria for specific infections for surveillance purposes. All the Loeb definitions herein shall be utilized in determining diagnosis and treatment. The Loeb criteria indicated the following: * Suspected UTI (Urinary Tract Infection, for patients with a chronic indwelling catheter, at least 1 of these symptoms: fever over 100 degrees F (Fahrenheit) or increase of 2.4 degrees above baseline, new (flank pain), rigors (shaking chills), delirium. For patients without a chronic indwelling catheter, acute dysuria OR fever over 100 degrees F or increase in 2.4 degrees F above baseline temp, AND AT LEAST ONE new or worsening: urgency, frequency, suprapubic pain, gross hematuria, flank pain or urinary incontinence AND ONE of the following microbiologic criteria; * At least 10 to the fifth power colonies per ml (milliliter) or not more than 2 specimens of microorganisms in a voided urine specimen. * At least 10 to the second power colonies per ml of any number of organisms in a specimen collected via straight catheter procedure. 1. Review of the infection line list generated by the facility indicated member #31 presented with dysuria (painful urination) and flank pain on 1/8/15. Review of nursing entries dated 1/7/15 and 1/8/15 indicated the member presented with	F 329		

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hallucinations and denied, "any urinary signs and symptoms of infection." Under the nursing documentation subtitle, "Surveillance criteria member without indwelling catheter", the nursing documentation indicated, "Hallucinations and positive UA (Urinalysis)." NP (Nurse Practitioner)-H evaluated the member on 1/8/15 and ordered a laboratory work up to include complete blood count, UA and basic metabolic panel.

Review of the laboratory data indicated a normal white blood cell count (a high white blood count could be an indicator of infection), normal basic metabolic panel and a clean catch UA with moderate blood, large leukocytes and packed white blood count field. The member was placed on a twice daily antibiotic Macrobid for 7 days on 1/8/15, with a diagnosis of, "UTI". The corresponding UC (Urine Culture) dated 1/9/15, indicated "Multiple organisms recovered. Repeat culture as clinically indicated." No antibiotic sensitivity testing was indicated due to the results of the UC. The member's primary care physician ordered a repeat UC on 1/9/15. The UC was obtained on 1/12/15, via an in an out catheter and the results indicated no uropathogens were present in the urine. It was noted by 1/12/15, the member had received several doses of an antibiotic medication.

On 1/27/15 at 1:20 p.m., surveyor #21654 interviewed NP-H regarding member #31. NP-H stated, the member (#31) had a history of a chronic knee infection that was open and draining. (The member) was on Bactrim prophylactically on a chronic basis. With hallucination and the knee infection, I conducted a work up to see if the knee infection was flaring,

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or if he had a UTI and since (the member) was on Sinemet and Prednisone, I was concerned that these med's can cause hallucinations. The member has Parkinson's and in December (2014) was having brief episodes of hallucinations. We decreased (the member's) Sinemet which helped with the hallucinations and have decreased the medication again in the mean time which was also effective. (The member's) vitals were good. (The member) is quite reliable and is own person. Once an antibiotic is initiated, a repeat urine culture is not real helpful for diagnosis. It would have been better to get a cleaner urine specimen before the antibiotic was initiated. I'm not sure why (the member) was started on an antibiotic. (Member's) primary care doctor initiated that."

On 1/27/14 at 1:30 p.m., surveyor #21654 interviewed DON (Director of Nursing)-A regarding member #31. DON-A verified to the surveyor that symptom information for the infection line list was gathered from the member's medical record and verified that there was no indication in member #31's nurses notes that the member had presented with dysuria or flank pain and the only symptom the member displayed was hallucinations (1/7/15-1/8/15). DON-A further verified to the surveyor that the 1/9/15 UC results and member #31's symptoms did not meet the facility's criteria for definition of infection or laboratory criteria for treatment with antibiotics. Surveyor: 26437

2. On 1/23/15 surveyor #26437 reviewed the closed medical record of member #15. Nurses notes dated 11/2/14, indicated member #15 experienced paranoid behaviors, "I think everyone is out to get me in this building."

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Nurses notes dated 11/3/14 indicated, "Member continues to fixate on the water...T 98.4...member denies bowel and bladder complaints...MD updated on hallucinations, paranoia, and behaviors."

Nurses notes dated 11/4/14 indicated, "Member does not have a chronic indwelling catheter, Loeb criteria met? No...denied burning, chills, elevated temp, frequency, urgency...(temp) 97.5...Urine C & S (culture and sensitivity) ordered...Member returned from...ER...diagnosed with UTI, started on Ciproflaxacin 500 mg every 12 hours x 5 days, VSS (Vital Signs Stable) denies dysuria or abdominal/flank pain.

Nurses notes dated 1/5/14 indicated, "Member...was reluctant to take new antibiotic and (physician) was informed and was changed to Levaquin which is a daily dosing to make it easier to get member to take medications."

Laboratory results for member #15, dated 11/4/14 indicated, "Colony Count >10,000 but less than 100,000 organisms/ml. Multiple organisms present; probable contaminants." The signed physician hand written note on the bottom of the lab report indicated, "No UTI, 11/18/14."

A physician's progress note dated 12/2/14, indicated "Member #15 has had a difficult month. (Member) has had two hospitalizations...both of these were precipitated by significant changes in behavior. At one of these admissions they thought it may have been secondary to a UTI. However, the subsequent culture result was negative..."

On 1/23/15 at 2:30 p.m., surveyor #26437

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F 329	Continued From page 15 interviewed ADON (Assistant Director of Nursing)-B, who confirmed member #15 experienced a new onset of hallucinations and escalating behaviors 11/2/14 to 11/4/15 resulting in a transfer to hospital emergency room. ADON-B verified that although member #15 did not demonstrate symptoms consistent with a UTI, the hospital diagnosed a UTI and treated the member with Ciproflaxacin. Because of the member's non-compliance with twice daily dosing, the antibiotic was changed to Levaquin on 11/5/14. On 1/26/15 at 2:00 p.m., ADON-B confirmed to surveyor #26437 via interview, that urine culture results were not reviewed until 11/18/14, there was no infection present for member #15 and the member had the full course of antibiotics.	F 329		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program	F 441		

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F 441	Continued From page 16 determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Surveyor: 21654 Based on record review and staff interviews, the facility had not established and maintained an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection in the following areas; 1. The facility's IP's (Infection Preventionist's) were not following the facility's standard of practice regarding infection surveillance and were not reviewing line list of antibiotic use and infections until the end of the month to ensure the standards for meeting clinical criteria/ laboratory criteria for use of antibiotics were being utilized. Ultimately 2 (member #31 and #15) received	F 441		

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antibiotics without meeting clinical criteria and/or laboratory criteria for definitions of infections. When calculating monthly infection rates for the facility, the computer printout utilized to acquire the data did not include the symptoms of infection or culture reports. The data indicated the member's name, type of antibiotic, and site of infection. No overview of the infection line lists were conducted.

2. The infection line list that indicated symptoms of infection did not correlate with actual symptoms member #31 had presented with.

3. The infection line lists were not complete and did not include 2 (member #32 and #33) member's known infections therefore, accurate infection rates were therefore not being calculated correctly.

4. IP staff responsible for calculating rates of infections and responsible for overseeing the standards of practice for appropriate antibiotic use had not been inserviced thoroughly in the area of infection surveillance.

Findings include:

The facility's standard of practice regarding infection tracking and surveillance dated June of 2013 indicated surveillance is defined as a systematic method of collecting, consolidating, and analyzing data concerning the distribution and determinants of a given disease or even, followed by dissemination of the information to those who can improve outcome. The DON (Director of Nursing)/ADON (Assistant Director of Nursing) of each building shall review the Infection Control line List Report in the computer

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at least once a week. Based on information obtained through the infection line list report and surveillance, recommendations for changes to policies and procedures, equipment/supplies, systems or processes, additional staff training and member information/education shall be made to appropriate supervisors.

ANTIBIOTIC STEWARDSHIP/INFECTION SURVEILLANCE.

The facility utilized the Loeb criteria for standard of practice for clinical definitions of infections. The Loeb criteria indicated the purpose of the criteria was to define the criteria used to determine treatment with antibiotics and to define the criteria for specific infections for surveillance purposes. All the Loeb definitions herein shall be utilized in determining diagnosis and treatment. The Loeb criteria indicated the following:

* Suspected UTI (Urinary Tract Infection), for patients with a chronic indwelling catheter, at least 1 of these symptoms: fever over 100 degrees F (Fahrenheit) or increase of 2.4 degrees above baseline, new (flank pain), rigors (shaking chills), delirium.

For patients without a chronic indwelling catheter, acute dysuria OR fever over 100 degrees F or increase in 2.4 degrees F above baseline temp, AND AT LEAST ONE new or worsening: urgency, frequency, suprapubic pain, gross hematuria, flank pain or urinary incontinence AND ONE of the following microbiologic criteria;
* At least 10 to the fifth power colonies per ml (milliliter) or not more than 2 specimens of microorganisms in a voided urine specimen.
* At least 10 to the second power colonies per ml

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of any number of organisms in a specimen collected via straight catheter procedure.

Antibiotic Stewardship: Antimicrobial stewardship refers to coordinated interventions designed to improve and measure the appropriate use of antimicrobial by promoting their use for actual infections.

The facility policy and procedure titled, "Definitions of Infections," revised 4/13, indicated, "Antibiotic Stewardship...refers to coordinated interventions designed to improve the appropriate use of antimicrobials by promoting their use for actual infections (those that meet the infection definition that can be treated with an antibiotic)...the selection of the optimal antimicrobial drug regimen...dose, duration of therapy and route...All the Loeb definitions herein shall be utilized in determining diagnosis and treatment...When infection is diagnosed: Always review current medication to ensure the dosage is still appropriate...Suspected UTI (Urinary Tract Infection, for patients with a chronic indwelling catheter, at least 1 of these symptoms: fever over 100 degrees F (Fahrenheit) or increase of 2.4 degrees above baseline, new (flank pain), rigors (shaking chills), delirium. For patients without a chronic indwelling catheter, acute dysuria OR fever over 100 degrees F or increase in 2.4 degrees F above baseline temp, AND AT LEAST ONE new or worsening: urgency, frequency, suprapubic pain, gross hematuria, flank pain or urinary incontinence."

1. Review of the infection line list generated by the facility indicated that member #31 presented with dysuria and flank pain on 1/8/15. Review of nursing entries dated 1/7/15 and 1/8/15 indicated

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the resident presented with hallucinations and had denied, "any urinary signs and symptoms of infection." Under the nursing documentation subtitle, "Surveillance criteria member without indwelling catheter", the nursing documentation indicated, "Hallucinations and positive UA (Urinalysis)." NP (Nurse Practitioner)-H evaluated the member on 1/8/15 and ordered a laboratory work up to include complete blood count, UA and basic metabolic panel.

Review of the laboratory data indicated a normal white blood cell count (a high white blood count could be an indicator of infection), normal basic metabolic panel and a clean catch UA with moderate blood, large leukocytes and packed white blood count field. The member was placed on a twice daily antibiotic Macrobid for 7 days on 1/8/15 with a diagnosis of, "UTI". The corresponding UC (Urine Culture) dated 1/9/15 indicated, "Multiple organisms recovered. Repeat culture as clinically indicated." No antibiotic sensitivity testing was indicated due to the results of the UC. The member's primary care physician ordered a repeat UC on 1/9/15. The UC was obtained on 1/12/15 via an in an out catheter and the results indicated no uropathogens were present in the urine. It was noted by 1/12/15, the member had received several doses of an antibiotic medication.

On 1/27/15 at 1:20 p.m., surveyor #21654 interviewed NP-H regarding member #31. NP-H stated "(#31) had a history of a chronic knee infection that was open and draining. (#31) was on Bactrim prophylactically on a chronic basis. With hallucination and the knee infection, I conducted a work up to see if the knee infection was flaring, or if (#31) had a UTI and since (#31)

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was on Sinemet and Prednisone, I was concerned that these med's can cause hallucinations. The member has Parkinson's and in December (2014) was having brief episodes of hallucinations. We decreased (#31's) Sinemet which helped with the hallucinations and have decreased the medication again in the mean time which was also effective. (#31's) vitals were good. The member is quite reliable and is (#31's) own person. Once an antibiotic is initiated, a repeat urine culture is not real helpful for diagnosis. It would have been better to get a cleaner urine specimen before the antibiotic was initiated. I'm not sure why (#31) was started on an antibiotic. (Member's) primary care doctor initiated that."

On 1/27/14 at 1:30 p.m., surveyor #21654 interviewed DON (Director of Nursing)-A regarding member #31. DON-A verified to the surveyor that symptom information for the infection line list was gathered from the member's medical record and verified that there was no indication in member #31's nurses notes that the member had presented with dysuria or flank pain and the only symptom the member displayed was hallucinations (1/7/15-1/8/15). DON-A further verified to the surveyor that the 1/9/15 UC results and member #31's symptoms did not meet the facility's criteria for definition of infection or laboratory criteria for treatment with antibiotics.

2. Review of the facility infection line list did not list member #32 as having been diagnoses with pancreatitis per the hospital summary record dated 11/17/14. The member had been placed on the antibiotic Ciprofloxacin at the same time due to UTI, returned to the facility on NPO (nothing by mouth) and with IV (Intravenous) fluids ordered.

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On 1/27/15 at approximately 3:00 p.m., DON-A indicated to surveyor #32767 that member #32 had not been placed on the infection line list for GI (gastrointestinal) infection of pancreatitis, because the member had not received antibiotics for that diagnosis. The facility's GI infection rates for the month of November 2014 would not have been accurate due to the omission. On 1/27/15 at approximately 1:10 p.m., the omission was verified by DON-A to surveyor #21654.

3. Member #33 was hospitalized from 10/25/14-10/30/14 with diagnosis of UTI. The member was readmitted to the facility on 10/30/14 on antibiotic therapy for diagnosis of UTI.

Review of the infection line list dated 10/26/14-1/26/15, did not indicate member #33 was listed as having a UTI. The facility's UTI infection rates for the month of October 2014 would not have been accurate due to the omission. On 1/27/15 at approximately 1:00 p.m., the omission was verified by ADON-B to surveyor #21654.

On 1/26/15 at 2:00 p.m., surveyor #21654 interviewed DON-A and ADON-B. Both staff indicated that weekly overview of the member infection line lists had not been completed, and both staff reviewed only the infection control surveillance computerized print out on a monthly basis when calculating infection rates. DON-A stated "We hear when members are placed on antibiotics or have an infection during daily stand up meetings which involve all unit managers. We don't ask particulars as to what symptoms members are having or what the lab results are.

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We rely on our unit managers to ensure that members are receiving the right antibiotic for the right reason and that infection criteria is met. We don't always make sure the cultures are in house when members are seen outside of the facility."

On 1/26/15 at 2:05 p.m., surveyor #21654 interviewed IP (Infection Preventionist)-I. IP-I functions as the Campus Wide IP. IP-I stated, "We have recognized that our computer system for tracking infections needs to be streamlined and we have had four meeting regarding that. Once that process is in place, we will education the building IP's. I am the campus wide IP and have been in the position for a very short time. It is the responsibility of the ADON and DON of each building to look at the infection line lists at least weekly to ensure accurate data is being obtained and that members are meeting the clinical and laboratory criteria for defining infections."

On 1/27/14 at approximately 1:15 p.m., ADON-B verified to surveyor #21654 that the infection rates were calculated from an infection control surveillance list that was generated by the computer. The list had member name, date of infection, antibiotic used and type of infection listed. ADON-B also indicated that review of members with enhanced precautions list was also reviewed to determine infection rates. The surveillance list did not include member symptoms or specific laboratory results to make a determination whether members on the list had met the clinical and/or laboratory criteria for definition of infections.

STAFF EDUCATION IN INFECTION PREVENTION /INFECTION SURVEILLANCE

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The facility utilized several spread sheets each with information regarding member infections. The ADON is responsible for calculating rates of infections monthly and utilized the spread sheet entitled "Infection Control Surveillance" which lists member's names, date of onset of infection, site of infection and type of antibiotic utilized. The ADON also reviews the members with enhanced precautions list during the review to calculate rates of infections in the facility.

The ADON job description dated January 2015 includes, "Reviews, supervises, and follows up on all infection reports, providing feedback to the DON, Infection Control Specialist and Medical Director." Knowledge, skills and abilities include,"Infection control principles and practices."

The DON job description (no date included) includes, "Supervision of the ADON and assign projects appropriate to knowledge, education and job role." Knowledge, skills and abilities include, "Infection control principles and practices."

On 1/27/15 at approximately 1:35 p.m., surveyor #21654 interviewed ADON-B. ADON-B verified to the surveyor that she had been in the ADON position for a short time and had only calculated rates of infections in the facility for the month of December 2014. ADON-B further verified to the surveyor that the only directive or education she had received regarding infection surveillance was a written directive, age of directive unknown, that indicated to her to utilize the computerized infection control surveillance list and members on the enhanced precaution list for the data. ADON-B indicated no other education had been

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received regarding need to monitor infection line lists weekly; that data regarding member symptoms and laboratory reports were the IP's responsibility to review and reeducate staff and physician's when necessary; and need to ensure all members with infections were included on the line list to ensure correct infection rates for the month.

Surveyor: 26437
4. On 1/23/15 surveyor #26437 reviewed the closed medical record of member #15. Nurses notes dated 11/4/14 indicated, "Member does not have a chronic indwelling catheter, Loeb criteria met? No...denied burning, chills, elevated temp, frequency, urgency...(temp) 97.5...Urine C & S (culture and sensitivity) ordered...Member returned from...ER...diagnosed with UTI, started on Ciproflaxacin 500 mg every 12 hours x 5 days, VSS (Vital Signs Stable) denies dysuria or abdominal/flank pain.

Laboratory results for member #15, dated 11/4/14 indicated, "Colony Count >10,000 but less than 100,000 organisms/ml. Multiple organisms present; probable contaminants." The signed physician hand written note on the bottom of the lab report indicated, "No UTI, 11/18/14."

A physician's progress note dated, 12/2/14 indicated, "Member #15 has had a difficult month. (Member) has had two hospitalizations...both of these were precipitated by significant changes in behavior. At one of these admissions they thought it may have been secondary to a UTI. However, the subsequent culture result was negative..."

On 1/23/15 at 2:30 p.m., surveyor #26437

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WI VETERANS HM STORDOCK 700	N2665 CTY RD QQ KING, WI 54946

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 26 interviewed ADON (Assistant Director of Nursing)-B regarding member #15. ADON-B confirmed member #15 experienced a new onset of hallucinations and escalating behaviors 11/2/14 to 11/4/15 resulting in a transfer to hospital emergency room. ADON-B verified that although member #15 did not demonstrate symptoms consistent with a UTI, the hospital diagnosed a UTI and treated the member with Ciproflaxacin. Because of the member's non-compliance with twice daily dosing, the antibiotic was changed to Levaquin on 11/5/14. On 1/26/15 at 2:00 p.m., ADON-B confirmed to surveyor #26437 via interview, that urine culture results were not reviewed until 11/18/14, there was no infection present for member #15 and the member had the full course of antibiotics.	F 441		